

|                       |              |                              |            |
|-----------------------|--------------|------------------------------|------------|
| <b>Case Number:</b>   | CM14-0169829 |                              |            |
| <b>Date Assigned:</b> | 10/20/2014   | <b>Date of Injury:</b>       | 01/13/2013 |
| <b>Decision Date:</b> | 11/21/2014   | <b>UR Denial Date:</b>       | 10/03/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 10/14/2014 |

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a patient with a date of injury of 1/13/13. A utilization review determination dated 10/3/14 recommends non-certification of PT, chiro, and massage therapy. Electro acupuncture was certified. The reviewer noted prior treatment including PT, chiro, and massage therapy. It referenced a 9/11/14 medical report identifying 6/10 pain with tenderness in the left second interphalangeal space, positive Finkelstein's, and painful flexion, abduction, and extension of the [illegible, presumably shoulder].

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Physical therapy QTY: 3:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99 of 127.

**Decision rationale:** Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend up to 10 sessions with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. Within the documentation available for review, there is documentation of completion of prior PT sessions,

but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. In light of the above issues, the currently requested physical therapy is not medically necessary.

**Chiropractic treatment QTY: 3:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60 of 127.

**Decision rationale:** Regarding the request for chiropractic care, Chronic Pain Medical Treatment Guidelines support the use of chiropractic care for the treatment of chronic pain caused by musculoskeletal conditions. Guidelines go on to recommend a trial of up to 6 visits over 2 weeks. With evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be supported. Treatment is not supported for the forearm, wrist, and hand. Within the documentation available for review, there is no evidence of objective functional improvement with prior chiropractic treatment and no clear rationale for treatment for a patient with predominantly wrist/hand pain given the lack of support for treatment of this body part per the CA MTUS. In light of the above issues, the currently requested chiropractic care is not medically necessary.

**Massage therapy QTY: 2:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 60.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60 of 127.

**Decision rationale:** Regarding the request for massage therapy, Chronic Pain Medical Treatment Guidelines state the massage therapy is recommended as an option. They go on to state the treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4 to 6 visits in most cases. Within the documentation available for review, there is no documentation of objective functional improvement from prior massage therapy sessions and current symptoms/findings suggestive of the need for additional sessions rather than adherence to an independent home exercise program. In the absence of clarity regarding those issues, the currently requested massage therapy is not medically necessary.